

Healthcare Policies and the Knox County Guatemalan Population

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Universal Declaration of Human Rights, Article 25, Section 1

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Declaración Universal de los Derechos Humanos, Artículo 25, Sección 1

Toda persona tiene derecho a un nivel de vida adecuado que le asegure, así como a su familia, la salud y el bienestar, y en especial la alimentación, el vestido, la vivienda, la asistencia médica y los servicios sociales necesarios; tiene asimismo derecho a los seguros en caso de desempleo, enfermedad, invalidez, viudez, vejez u otros casos de pérdida de sus medios de subsistencia por circunstancias independientes de su voluntad.

At Tu'malaal Kopib'il Twi'yalaal Kaawb'il B'ix Niinb'il, Tjuwe'yan tkya'wnaqi'n tiipaky'

25 (Mam)

Kyaqiil xjaal at tokleen ti'j anq'ib'il tuj tu'malxix tu'n tkoleet tuj yaab'il, tu'n twa'n, tu'n t-xb'alamaan, qa juna'wax ma tooqaj aax at tokleen ti'j anq'ib'il b'antzala koox.

Uq'alajisaxik Pa Ronojel Uwachulew Ri Ya'talik Kab'an Pa Ri K'aslemal, Ro' ukak'al

taqanik 25 (K'iche')

Ronojel winaq ya'tal chech kak'o'ji' junelik utzalaj k'aslemal ruk', xuqe chkech konojel ri e upa ro'ch; ya'talik kak'o'ji' utzwachil chkixo'l, chwi ri kutijo, karatz'yaqib'ej; kak'o'ji' pa ri rachoch, rajawaxik ka'ilixik kakunax kumal taq le kunanelab', kato'ik we na tz'aqat ta che ri uchomanik, kato'ik pwi ri yab'ilal, ri'job'ik, xuq we maj uchak. Xuq la je' we ne' kuriq jun nimalaj k'eyowal che ri maj chi nab'exkil.

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Introduction

East Tennessee Children's Hospital (ETCH) is a children's hospital located in Knoxville, Tennessee, and it serves a large portion of East Tennessee and even some parts of southeastern Kentucky and western North Carolina. In order to better treat the growing Hispanic population in the Tennessee Valley and Appalachia, ETCH began to offer Spanish translation services through a staff of interpreters. While enrolled in a service learning course through the University of Tennessee Spanish department, I shadowed these interpreters to gain better insight into the challenges and cultural differences that go along with treating this population. I began to see how barriers such as language, different conceptions of illness and miseducation all made the process of healing more challenging and how these interpreters helped bridge the linguistic and cultural divides to overcome those challenges.

As I was exposed to more patient interactions, I began to realize that one Latin American group was being left out, despite ETCH's greatest efforts. This community was the Knox County Guatemalan population, specifically indigenous Guatemalan immigrants. I saw these patients struggling to communicate with physicians and interpreters in a mix of broken Spanish and English because their native tongue was Mam, K'iche' or some other indigenous language. I saw the poverty that usually followed these patients even more so than the other Hispanic families that came through ETCH's doors, and I began to wonder what made these populations so different from the other immigrants from Mexico and other Central American countries. This project began with questions about this community's demographics, their cultural beliefs about health and their history. What led them to immigrate to a country where they did not even speak

Spanish, the country's second most common language, much less English? Most importantly, I wanted to know how we could improve their health, provide more culturally competent care and target them with specific education that might help to support health equity in this community.

Knox County, the county in which Knoxville is situated, is located in the center of the Tennessee Valley in East Tennessee with the city of Knoxville anchoring the county economically. Originally used by the Cherokee as hunting grounds, the area was originally colonized in 1786 by James White, and over the course of the next decade it experienced significant growth even boasting Blount College, the forerunner of the University of Tennessee, due principally to its central location and its new status as the capital of the Southwest Territory. Throughout the nineteenth century, Knoxville continued to benefit from its central location becoming a transportation hub. Like many cities in the South, it suffered heavily during the Civil War although not as heavily as other cities in the Deep South. Following the war, Knoxville began to rebuild its economy through the vast natural resources of the area such as lumber, coal and especially marble, with Knoxville even being widely known as the Marble City ("History of Knoxville," 2013). The Great Depression put an end to this short-lived economic prosperity, but the ensuing New Deal reforms led to important infrastructural developments that improved flood management and helped create cheap electricity for the region through the creation of the Tennessee Valley Authority (Cohen, 2002; "History of Knoxville," 2013).

Knoxville experienced a period of renewal during World War II (WWII) as local industries such as Aluminum Company of America (ALCOA) flourished supplying the

government, but throughout the 50s and 60s economic stagnation began to set in again. Suburbanization began draw wealthier individuals out of the city and into new neighborhoods on its outskirts and outside of city taxes. Despite losing a significant portion of their tax base, the conservative policies of the mayoral office and the city commission prevented the city government from raising taxes and annexing significant portions of the county to recapture many of those suburbanites. These policies led to the deterioration of the downtown area and an exodus of downtown anchors like Miller's Department Store which had been a staple on Gay Street. Hints of change began to appear in the late 60s with the expansion of the University of Tennessee bringing new funds and diversity and a new administration under mayor Kyle Testerman (1972-1975). During his first tenure progressive policies were initiated in order to attract more businesses downtown and the planning for the 1982 World's Fair began (Wheeler, 2005).

The World's Fair was designed to revive the ailing downtown area, but the day after the fair ended, the United American Bank (UAB) led by Jake Butcher was raided by the Federal Deposit Insurance Company (FDIC) and discovered to be insolvent. At the time, the failure of UAB was the fourth largest bank failure in US history, and while the financial repercussions were mitigated by First Tennessee's purchase of UAB, it proved to be a psychological blow to the city and its downtown renewal efforts. Nevertheless, Mayor Testerman's second term (1984-1987) of office saw new investments in the downtown area that improved Market Square and Gay Street. The tenure of his successor Victor Ashe (1987-2003) expanded the city's tax base by annexing larger swaths of Knox County allowing for further investment in and development of the downtown area (Wheeler, 2005). During the terms of Bill Haslam (2003-2011) and Madeline Rogero

(2011-) this trend has continued and has attracted a number of downtown anchors such as the Mast General Store, Regal Cinemas and Urban Outfitters that support downtown residents and attract suburbanites back downtown (Hunter, 2007). Through these policies downtown Knoxville is currently experiencing a renaissance through improved development, retail and an increasing population in these areas has led to a more diverse and open Knoxville.

The development of this new, more cosmopolitan Knoxville and Knox County has coincided with a significant demographic change within the United States (US) as a whole. During the last three decades, the Hispanic population of the US has skyrocketed, and a similar trend has been seen in Knox County. Hispanics are beginning to become more evident in the community. Knoxville boasts a number of nonprofit organizations that specifically cater to Hispanics with the main organizations being the Hispanic Chamber of Commerce of East Tennessee (HCCET), HoLa and the Centro Hispano de East Tennessee (Centro Hispano). HCCET aims to promote Hispanic economic development within East Tennessee by helping businesses network, make connections and monitor legislation to promote Hispanic business interests (Hispanic Chamber of Commerce of East Tennessee). HoLa works principally to promote Hispanic culture in Tennessee through their annual HoLa Festival celebrated during Hispanic Heritage month. They have also recently begun promoting local Hispanic artists through Casa HoLa which showcases these artists during the month's First Friday art gallery openings (HoLa). Centro Hispano focuses much more on helping Hispanics living around Knoxville develop personally and professionally through GED, ESL and financial education classes along with free legal advice through their legal clinic (Centro Hispano).

Many of these organizations are reaching out to help Hispanics develop economically, continue to participate in their culture and receive education and other services that will help them function successfully here in the US. Unfortunately, access to affordable and culturally competent care is still lacking for many individuals, especially the less represented communities that have immigrated from Central America and may have vastly different cultural beliefs compared to the larger and more well-known Hispanic groups like the Mexicans, Puerto Ricans and Cubans. Oftentimes Hispanics are treated as a homogeneous group when the opposite is actually the case. Hispanics are no more homogeneous than the Anglophone or Francophone worlds and perhaps even less so. For this reason, the focus of this work is on the health of Knox County's Guatemalan community. By focusing on the Guatemalan community, the aim is to better understand one community, its unique historical and cultural background and how these topics relate to their healthcare.

The first section focuses on Hispanic and specifically Guatemalan immigration to the US and some of the cultural issues that providers should be aware of for Guatemalan patients, especially the difference between the Ladinos and Mayans. The second section is an overview of the Guatemalan healthcare system. In order to successfully advocate for and reach out to this community it is important to understand the type of healthcare that immigrants are used to receiving in their home country as to better understand where and how patients will be receptive to receiving care in Knox County. The next section covers the healthcare available to Guatemalan immigrants here in Knoxville and incorporates some of the research done by Sean Barton and Craig Bleakney on Hispanics in Knoxville. This section attempts to highlight organizations that can be of help to these

immigrants and the pros and cons of these organizations. The final section of this text focuses on providing policy recommendations to improve the healthcare of these immigrants and reiterate some of the key themes that this document aims to emphasize.

Hopefully this text can help improve the quality of care that Guatemalans receive by highlighting cultural, political and economic situations of which providers should be aware. It attempts to incorporate previous research done on Hispanic health in the community and how it specifically relates to the Guatemalan community. At the same time, it aims to demonstrate the heterogeneity of Hispanics. By better understanding how to improve healthcare for Knox County's Guatemalans, lessons can be learned that can be adapted to improve care for other Latin American immigrants and even immigrants from other underdeveloped portions of the world.

I would briefly like to note how some important terms are used throughout this text so that confusion can be avoided. In every day conversation Hispanic and Latin American are generally interchangeable, but this text presents a Latin American group that is not Hispanic—the indigenous Guatemalans. If I need to refer to the entire populations of Latin American countries in this text then I use Latin American. This term includes all Hispanic (i.e. Spanish speaking), Lusophone and indigenous individuals. If I mean to refer solely to Hispanics then I am referring solely to individuals who speak Spanish as their principal language, and I usually use this term to contrast with indigenous or Mayan which signify the Native American populations who speak native languages and have varied cultural beliefs. The only exception to this usage is when I am referring to data collected by the US Census Bureau which combines indigenous Latin

Americans as Hispanic. If I refer to the citizens of Guatemala as a whole then I use this term to include both Ladino and indigenous citizens.

A Nation of Immigrants: Changing Demographics

The United States is marketed as a nation of immigrants. We learn about the British colonization of the Americas, the tides of European immigrants who flooded through Ellis Island from 1892 to 1954 and many of us remember the words engraved into the Statue of Liberty: “Give me your tired, your poor, Your huddled masses yearning to breathe free.” We celebrate this history as we rightly should, and it is not uncommon to hear people speak proudly of their German, Italian or Irish ancestry. Nevertheless, our rhetoric is lacking because it ignores the discrimination and vitriol that many of these immigrants were met with, and it almost completely disregards immigrants from non-European backgrounds such as Africans, Asians and most importantly for this text, Hispanics (Cohen, 2002).

Hispanic immigration has recently risen to the national stage as the debate on unauthorized immigration has intensified, but it began long before it became such a contentious political issue. Mexicans have historically come to the United States in greater numbers than any other Hispanic group principally due to the proximity and long border that Mexico shares with the US. The first wave of Mexican “immigration” came with the Treaty of Guadalupe Hidalgo when the United States purchased the vast majority of the southwestern United States from Mexico following the Mexican-American War (Allan R. Millet, 2012). Mexican immigration then went through a period of ebbs and flows. With the border being so fluid, it was easy for Mexicans to cross the border seasonally for work and then return to Mexico following their labor (Garza, 2009).

At the beginning of the twentieth century, Mexican immigration began to increase until the Great Depression sent many immigrants back to Mexico both voluntarily and at the hands of the US government. As a fact, from 1930 to 1939, Mexicans made up 46% of deportations from the United States (Garza, 2009). In 1939, outside events transpired that changed US policy towards Mexican immigrants which initiated the Braceros program to bring in Mexican workers principally for agricultural work as many US men were inducted into the military for World War II (WWII).

Following WWII, the Braceros program was continued, and in addition to Mexican immigration, many Puerto Ricans began moving to the continental United States during the 1950s and 1960s in what was known as the “Great Migration.” Eventually the number of Puerto Rican immigrants began to decline, but due to economic and political instability that set in in Mexico during the 1980s, immigration began to increase significantly (Garza, 2009; Lopez, 2014). The net Mexican immigration to the United States during this period was an important part of the growing US Mexican population, but as of 2005, net immigration between the two countries has fallen to practically zero. The increasing Mexican population is now due almost entirely to differences in birth rates between Mexicans and other demographic groups within the United States (Gonzalez-Barrera, 2012).

As of the 2010 census, the Hispanic population accounted for 16.3% of the US population, and within this 16.3% Mexicans accounted for 63.2% of Hispanics (10.3% of the total US population) with Puerto Ricans making up 9.2% (1.5% of the total US population) (United States Census Bureau, 2010c). These two groups make up the single largest Hispanic groups in the US as a whole, and while the Hispanic populations of

Tennessee and Knox County are significantly lower than the national average at 4.6% and 3.5%, respectively, Mexicans and Puerto Ricans are similarly represented in the proportion of the Hispanic population. Mexicans make up 64.3% of the statewide Hispanic population and 58.9% in Knox County while Puerto Ricans constitute 7.3% of the state Hispanic population and 8.6% of the Knox County Hispanic population (United States Census Bureau, 2010a, 2010b).

While Puerto Ricans and Mexicans make up the first and second largest Hispanic groups in the United States, recent immigration trends indicate that more Hispanics are beginning to immigrate from Central American countries such as El Salvador and Guatemala. Nationally, Salvadorans predominate as the largest Central American group, but in Tennessee and Knox County, the predominant group is Guatemalans who make up 4.9% of Tennessee's Hispanic community and 6.0% of Knox County's (United States Census Bureau, 2010a, 2010b).

With a population of approximately 15.5 million people in 2013, Guatemala boasts the largest population of any Central American country and a relatively large GDP of 53.8 billion USD which amounts to a GDP per capita of 3478 USD (The World Bank, 2013a, 2013b). The Human Development Index of Guatemala is 0.628 which corresponds to a medium development country, and its most recently reported GINI coefficient is 52.4 which indicates the high level of inequality (United Nations, 2014; World Bank, 2015). These numbers represent an economy that is currently in development but must work to overcome its history as it is still facing significant challenges. By analyzing the demographic and historical context of Guatemala we can

begin to better understand the Guatemalan population living in the United States and the forces that drove them to immigrate.

Demographically, Guatemala is different than many other Central American countries because of its indigenous population which makes up approximately 60% of the country. The remaining 40% are the Ladinos who descended from European immigrants, speak solely or primarily Spanish and have been the societal elite since the days of Spanish colonization. While Guatemalan immigrants are generally labeled Hispanic, the indigenous immigrants have very little in common culturally with the Ladinos and other Latin Americans, and many only have a basic grasp of the Spanish language (Odem, 2011). Historically, in the early 1950s the government of Jacobo Arbenz led a redistribution effort that aimed to take land from the United Fruit Company and redistribute it to Guatemalans, specifically rural and indigenous individuals, who needed land for farming and subsistence. In response to this attempt at nationalizing the holdings of a US company, the CIA supported a military coup which overthrew Arbenz and replaced him with Carlos Castillo Armas (Mejia, 2005). The policies of this new government led to a military uprising in 1960 that began the 36 year Guatemalan Civil War (Odem, 2011).

Immigration did not increase immediately following the outbreak of the war, but instead began increasing at the same time as other Central America nations during a period known as the Central American Crisis. This period ultimately began with the Sandinista Revolution in Nicaragua in 1979, and it also precipitated the beginning of the decade long Salvadoran Civil War (Mejia, 2005). In Guatemala the Central American Crisis coincided with a period of renewed repressive vigor of leftist and indigenous

Guatemalans on the part of Guatemalan government led by Efraín Rios Montt, and Guatemalan immigration, especially among the indigenous populations, increased as a result (Mejia, 2005; Odem, 2011). This systematic oppression of the indigenous populations ended with the signing of Peace Accords to end the Guatemalan Civil War in 1996, but the economic situation and rampant inequality of Guatemala led to the largest period of Guatemalan immigration with 74% of immigrating Mayans arriving in the United States in 1990 or later (Odern, 2011; Patten, 2011).

Upon arrival in the United States, many Mayans settled in the traditionally Hispanic areas such as California, Texas and other parts of the Southwest, but as economic opportunities and high costs of living took their toll, many Mayan immigrants began to settle in other parts of the country such as the South where today almost 34% of Mayan immigrants reside. Some of these more recent immigrants only came for a period of time in order to make money to jump start their lives in Guatemala while others came to settle permanently (Odern, 2011; Patten, 2011). Regardless of their intended length of stay, the vast majority of these immigrants are undocumented, and they face a number of difficulties shared by all undocumented workers such as unsafe work conditions, low pay and hostile attitudes towards Latin American immigrants that have arisen in post-9/11 America (Odern, 2011). Laws such as Arizona SB 1070 which expanded police officers' ability to check immigration status were at the extreme end of the spectrum, but many states including Tennessee have passed legislation that further limited their working conditions. The Tennessee Lawful Employment Act has required that all employers utilize E-verify in order to attain the immigration status of their employees or face hefty fines and penalties ("Tennessee Governor Signs Immigration Enforcement Law," 2011).

In addition to these challenges that are faced by most undocumented workers, Mayan immigrants also face added challenges such as the question of language. They speak a multitude of indigenous Mayan languages such as K'iche', Mam, Q'onjob'al and Chuj—languages commonly spoken in the Guatemalan highlands. Many of these immigrants have a very limited ability to express themselves in Spanish which further isolates them when they arrive in the US. They are often limited to communicating with only individuals who have immigrated from the same geographic area in Guatemala due to their limited Spanish capabilities and the limited mutual intelligibility among Mayan languages. They also face constant misidentification as Mexicans which is even more difficult for them than other Latin American immigrants because they do not fit into the Mexican community or any other Latin American community very well due to linguistic and cultural differences. In their country, there is a distinct divide between the Mayans and the Ladino elite who are linguistically and culturally much more similar to Hispanics like the Mexicans and other Central Americans (Lebaron, 2012).

Given these important demographic differences that differentiate Guatemalans from the Hispanic community as a whole, it is reasonable to expect that their demographics are distinct as well. In many areas, the demographic differences are negligible such as age, marital status and fertility. Guatemalans and Hispanics as a whole have a median age of 27, marital rates of 40% and 43%, respectively, and fertility rates of 9% and 8%, respectively. In other areas, the differences are extremely pronounced. Reflecting their more recent immigration to the United States than other Latin American groups, a significantly larger percentage of Guatemalans are foreign born (64%) than Hispanics as a whole (36%). They also have significantly lower levels of educational

achievement than Hispanics which leads to lower incomes and higher levels of poverty. The median earnings of a Guatemalan in the US is only \$17,000 compared to \$20,000 for Hispanics as a whole and \$29,000 for the average American. Also, 29% of Guatemalans live in poverty compared to 26% of Hispanics and 16% of the US population. Their access to health insurance is also significantly lower than Hispanics and the average American. Almost one-half of Guatemalans (46%) do not have health insurance compared U.S. Hispanics (30%) and the US population as a whole (15%), reflecting the large number of immigrants with undocumented status (Patten, 2011).

Understanding the demographics of the Guatemalan population on a national level provides a basis for beginning to realize the complexities of the Knox County Guatemalan community. These data help dismantle the idea that Latin Americans and Hispanics are somehow a homogenous group and instead emphasizes their heterogeneity. Comprehending the socioeconomic status, the history and the culture of this community is essential to providing culturally competent care and making sense of the unique challenges that this community faces in regards to obtaining medical care. This section attempts to communicate critical information that contextualizes the subsequent sections on the National Healthcare System of Guatemala and the healthcare they receive in Knox County. It emphasizes the fact that treating this community will require more than just an understanding of biomedical processes, rather a nuanced appreciation of the role that these socioeconomic status, history and culture play.

National Healthcare System of Guatemala

Guatemala has only just begun to rebuild and develop their infrastructure, economy and most importantly for this text, their health system since the signing of the

1996 Peace Accords that ended the Guatemalan Civil War (Mejia, 2005). The policies put into practice by the government throughout the civil war led to marked inequality in Guatemala, especially between the Ladinos and the indigenous Mayan populations. Despite the conclusion of the civil war, these inequalities are still very much present, especially throughout the Guatemalan Health System.

Guatemala's Health System consists of three main providers: government facilities operated by the Ministry of Public Health and Social Welfare (MSPAS), facilities operated by the Guatemalan Social Security Institute (IGSS) and the private sector. In 2005 the government spent 1.9% of its GDP which represented 11.8% of the government's overall spending. Highlighting the overall decrease in public spending by the Guatemalan government, these indicators decreased from their 1999 levels of 2.3% and 14.4%, respectively (Bowser & Mahal, 2011). In theory, the public services are available to all Guatemalans, and the nation's constitution even states that "El goce de la salud es derecho fundamental del ser humano, sin discriminación alguna"¹ (*Constitución Política de la República de Guatemala*, 1985). Unfortunately, in theory does not necessarily signify in practice, and these governmental programs primarily benefit Ladinos living in urban areas where the majority of these facilities are located (Jones, 1995).

Living in these urban areas may mean that more programs are available, but receiving and financing appropriate medical care still presents an enormous challenge for many Ladinos. Guatemalan public healthcare is characterized by the lack of availability of drugs and diagnostics, overcrowding and long wait times. These poor indicators pose a

¹ Enjoyment of health is a fundamental human right, without any discrimination
(Personal translation)

serious problem because with only 15% of Guatemalans having insurance of any kind, the vast majority will have to use these lacking MSPAS facilities. In addition to these access problems, significant financial barriers also stand in the way of many treatments and cause serious problems following treatment. It was reported in 2006 that 17.9% were faced with catastrophic health spending which was defined as health spending that exceeded 40% of a family's ability to pay. This number in and of itself is appalling, but if we examine the poorest 25% of Guatemalans, this number increases to 59.7% of the poorest who were faced with catastrophic healthcare spending in 2006 (Bowser & Mahal, 2011).

The poorest of Guatemalan society are more often than not the indigenous Mayans living outside urban areas like Guatemala City and Quetzaltenango (also known as Xela). These individuals often live in small communities where access to care is extremely sparse. Hospitals are concentrated in urban areas, and some of the larger communities might have a government run health center. Nevertheless, many individuals living in smaller communities are unable to access either of these systems due to problems with transportation. If these smaller communities are lucky, they will have a health promoter who is a community member trained to perform basic healthcare tasks such as provide vaccinations, administer first aid and provide referrals to larger clinics, but government funding often cuts these posts or significantly limits how effectively they can provide care to patients (Jones, 1995, p. 87). With government healthcare so limited, many Mayans must rely on non-governmental organizations (NGOs) if they are available and traditional Mayan medicine (Hawkins, 2007). In fact, a large number of Mayans prefer traditional medicinal treatment to western intervention for reasons of culture, cost

and ease of access. (Leyn, 1999). Often, they do not trust government organizations due to the oppression that they and their families suffered throughout the Guatemalan Civil War (Jones, 1995). This lack of trust and access leads many Mayans to consider pharmacies which do not require prescriptions as in most of Central America as their first source of access to western medicine which leads to poor health outcomes. Pharmacists are usually more interested in selling their products than providing accurate medical advice if even capable of it in the first place (Jones, 1995). This competition between western medicine and traditional Mayan medicine is a central theme that will be continually revisited as we discuss healthcare in Guatemala and will be important when we later consider its policy implications.

In order to understand Guatemalans' access to care and the quality of care they are receiving, essential health services will be discussed first and most thoroughly, but before that, a brief digression into the Mexican healthcare reform in the 1990s will help provide some context within Latin America and help define essential services. Mexico was facing a number of challenges similar to those of Guatemala, namely rural and indigenous populations that were receiving inadequate care through the then current Mexican healthcare system. Some more affluent areas of Mexico had life expectancies that were similar to highly developed countries in western Europe and North America, but rural and indigenous communities' health was more in line with developing countries like India whose life expectancy at birth is 66.3 years (Gómez-Sherlock, 2000; OECD, 2015b).

In response to growing dissatisfaction with mismanaged neoliberal reform efforts promoted by the World Bank and the International Monetary Fund (IMF) in the early

80s, Mexico initiated reforms that aimed, among other things, to improve the health of rural and indigenous Mexicans through a program known as the Program for the Extension of Coverage (PEC) focused on providing 12 basic interventions:

1. Basic household sanitation measures
2. Family Planning
3. Prenatal, natal and postnatal care
4. Nutrition and growth surveillance
5. Immunization
6. Treatment of diarrhea at the household level
7. Treatment of common parasitic diseases
8. Treatment of acute respiratory infections
9. Prevention and control of tuberculosis
10. Prevention and control of hypertension and diabetes
11. Prevention of accidents and initial treatment of injuries
12. Community training for health promotion

This program was largely unsuccessful due to a number of financial factors and its inability or its reluctance to satisfactorily address inequality, and a new wave of health reform had to be undertaken from 2003 to 2012. Nevertheless, for the purposes of this text, this program identifies a number of essential health services that are important to consider throughout this text in the context of the Guatemalan healthcare system and its relation to rural and indigenous populations (Gómez-Sherlock, 2000).

The largest public health issue facing everyday Guatemalans, and especially the indigenous, is malnutrition. Corroborating that statement, approximately 50% of

Guatemalan children have chronic malnutrition, and 54% of children under 5 have stunted growth (Loewenberg; Reurings, Vossenaar, Doak, & Solomons, 2013). These exceedingly high malnutrition and stunted growth rates are due in part to lack of nutrition education among the indigenous Mayans and in greater part due to the rampant inequality in Guatemala. In the Mayan culture foods that are high in carbohydrates such as tortillas and tamales, are highly revered because they are made of corn—the area's main agricultural product. For many indigenous Mayans corn is seen less as a food in itself and more of a medicine because without corn, many believe that one cannot continue to function (D. L. Lee, 2002; Rode, 2000). This reliance on corn causes many to leave out other important foods such as fruits, vegetables and to a lesser extent protein rich nourishment like beans, eggs and meat. While cultural ideas play a certain role in the prevalence of malnutrition, there have been a number of efforts to educate Mayans on a balanced diet in a culturally competent way, and these have not been extremely successful (D. L. Lee, 2002). This lack of success is likely due in large part to the extreme inequality in Guatemala that was mentioned previously. Rising food costs are preventing many individuals from accessing protein-rich foods that support healthy growth. Beans and eggs that were once accessible are less so due to higher costs, and meat has been out of the reach of many Mayans for much longer than eggs or beans (Loewenberg).

Training and financing qualified health promoters (i.e. local individuals with basic health training to provide primary care and referrals to larger institutions) is one of the main health problems facing the government, and the lack of appropriate training and financing contributes to a number of the other problems mentioned. Training programs

are conducted by the Ministry of Health and consist of a 140 hour course. A number of other courses are also sporadically offered in the use of medicinal plants and other basic health competencies. These programs are not intensive by any means, but they do provide the promoters with a basic level of understanding about important medical interventions such as vaccinations, medicinal plants and nutrition. The biggest problem for these health promoters is that the government does not provide them with adequate supplies or compensation for their time. These financial factors mean that promoters are unable to provide adequate care because they do not have the necessary tools, and the lack of financial compensation has led a number of promoters to work as if they were actually medical practitioners. Instead of fulfilling their roles as primary care providers and community educators and referring patients out if they have a serious illness, they attempt to treat these illnesses for personal financial gain. These issues also mean that the government is unable to place promoters in every community which brings back the issue of transportation and why communities are unable to sufficiently access appropriate care (Jones, 1995). Highlighting this lack of appropriate care, only 37.1% of children under the age of 5 with sustained diarrhea were treated appropriately with oral rehydration salts, and as of 2011, the leading cause of death in Guatemala was lower respiratory infections (*At a glance: Guatemala*, 2013; Centers for Disease Control, 2011). Through these two data, it is evident that the Guatemalan health system is incapable of reaching out and treating a number of basic illnesses.

PEC also highlights the importance of women's health issues such as family planning, prenatal, natal and postnatal care which remains an area of great need and importance in Guatemala, especially for the indigenous communities. Contraceptive use

among married Ladino women reached rates of 50% in 2001. While this rate is relatively low compared to the regional average (i.e. average of surrounding Central American countries) of 64%, it pales in comparison to the rates of contraceptive use among Mayan women which is only 13%. Surprisingly, it has been determined that access to contraceptives is no different for Ladino and Mayan women. On average Maya and Ladino women live approximately the same distance from health clinics offering family planning services and cost was rarely cited by Mayan women as a reason for not choosing birth control (Seiber & Bertrand, 2002). The real difference between the two populations are the cultural beliefs that they hold. These biomedical interventions do not coincide with their cultural view of health because they view these drugs as chemicals, and for them, all chemicals are harmful. This view leads them to believe that these medicines cause cancer and other illnesses (Rode, 2000).

Cultural issues play a significant role in Mayan maternal care as well. In Guatemala, the primary maternal care provider is the midwife. These midwives often see their work as a calling and very often, this role was given by a priest who informs these women that midwifery is their calling and that they have the right to practice. This view of midwifery presents certain benefits to the patients such as a provider that truly cares for them and one that understands their cultural beliefs and language, which is something unlikely to be found in the Ladino dominated hospitals. The flip-side to this problem is that many do not have even a basic understanding of western medical practices that can significantly improve patient outcomes (Wilson, 1996). Recently, the government has been trying to balance these cultural beliefs with proven biomedical interventions that can help to improve maternal health and reduce infant mortality at the same time. Currently,

the infant mortality in Guatemala is at 30 per thousand births which is more than double the infant mortality of Mexico and five times the infant mortality rate in the United States (Centers for Disease Control, 2011; OECD, 2015a; The World Bank, 2013b). The government is attempting to accomplish this improvement through improved training of these midwives so that they are more aware of sanitary practices such as washing hands during childbirth and knowing when a mother needs to be transported to a hospital for more advanced western biomedical care (Maupin, 2008; Wilson, 1996).

In theory, these training courses provide these individuals with basic western medical knowledge that can complement the on the job training they receive from other practicing midwives, but in 2005 the World Health Organization “stated that training traditional birth attendants... ‘is increasingly seen as a failure’” because there has been so little improvement in Guatemala’s infant mortality rate (Maupin, 2008). This lack of improvement is likely a result of many things: lack of support and compensation for the midwives, lack of education on the parts of midwives and patients, and most importantly, cultural beliefs at odds with sound medical knowledge. Guatemalan midwives receive very little support from the government, except for the provision of some basic equipment such as clamps and scissors, but the midwives have to provide essential tools such as sterile gloves, which means that they are not used during the birthing process. These midwives also receive no salary from the government and sometimes receive nothing from those who they treat which prevents them from making a sufficient living and obtaining tools and medicines for their patients (Wilson, 1996).

While many births are successfully attended to by these midwives, their lack of education in western midwifery practices presents a significant problem when it comes to

dealing with complications when they inevitably arise. Oftentimes, they are not able to recognize these complications and refer the patient to a medical practitioner. A common complication is breeching where the baby is not positioned correctly in the womb. A common practice by the midwives is to influence to baby's position through a series of massages, and while sometimes effective, they are not a reliable method of changing the baby's position which leads to more complicated and dangerous breech births. Additionally, midwifery training places very little emphasis on the child after birth so a host of problems arise following birth when the child is not properly attended (Wilson, 1996).

In Guatemala where such basic health issues such as nutrition, health training and women's health are immensely lacking, additional health services such as dentistry, visual health and mental health are even more severely lacking. For those living in urban areas and with sufficient funds, appropriate care can be found, but for poor Ladinos and even more so for the Mayan communities, these services are basically nonexistent (J. T. Lee, 2002; Sullivan, 2001). When dental problems arise, many Mayans just have to wait until the tooth falls out, and those who can afford it pay a dental practitioner (i.e. an individual who practices some aspects of dentistry without university training) to pull the tooth for them. There is also very little preventative measures that can or are being taken to prevent these dental problems from arising (J. T. Lee, 2002). In regards to visual health, there is very little data which posed a problem with the analysis of visual health services. One indicator that is available is the rate of blindness in Guatemala which is 4.1 percent—over twice as high as the rate of Mexico. But like Mexico, the vast majority of blindness is a result of cataracts which suggests that there are either not enough

ophthalmologists performing cataract surgeries, there are barriers to access like culture, transportation or fears of the government, or a mix of the two (Furtado et al., 2012). Finally, the field of mental health is also severely lacking, not only as a result of the lack of mental health practitioners but due to a lack of understanding of how depression manifests itself in rural Mayans. They tend to present somatic symptoms such as fatigue and pain which can lead to misdiagnosis. The whole concept of mental health treatment is also extremely foreign to them because many will see depression as a curse put upon them by another household or as a result of some other supernatural occurrence. In order to find healing, these individuals reported the church and social support such as spending time with family as the ways they were able to cope with sadness and depression (Sullivan, 2001).

One of the few essential services as outlined by PEC that is being adequately provided in Guatemala is vaccination. Vaccination rates in Guatemala for tuberculosis, polio, tetanus, and Hepatitis B are all above 90% which confers a host of important public health benefits. Guatemala is also making important strides in providing appropriate sanitation measures by increasing access to clean water and improving sanitation facilities (*At a glance: Guatemala*, 2013). Despite these important public health achievements, Guatemala is still struggling the other essential services outlined previously

The Guatemalan health system is a system in development, and while a number of indicators show improvement, it still has a long way to go. It is struggling to overcome rampant inequality that has fostered an environment of distrust between the Ladino and Mayan communities. It must also learn to bridge the cultural divides that separate these

two populations. In order to ensure health equity as promised by the nation's constitution, the system must facilitate more expansive and culturally competent care that takes care of those essential health services such as improving nutrition, training qualified medical practitioners and improving women's health throughout Guatemala. Significant improvements in these areas will lead to immensely better overall health for the Guatemalan population and will eventually allow for the expansion of other health services such as dentistry, visual health and mental health. The Knox County Guatemalans' experiences with the national Guatemalan health system will continue to inform their beliefs, perceptions and actions regarding care in Knox County. Some of the health inequities described in the following section are anticipated by the health inequities described in Guatemala and will serve to inform many of the policy recommendations in the final section.

Guatemalan Health in Knox County

We cannot discuss the national health system of the United States like we have with Guatemala because that implies that there is a system controlled on the national level. The US health system takes the trends towards privatization and decentralization seen in Guatemala and much of Latin American as a whole and carries them to an extreme because control is held at a myriad of levels including nationally and at the state and local levels. There is no central control over public health offices, the majority of hospitals and clinics are private, and there is no central government health coverage for everyone. Health coverage is provided through a number of public and private sources, depending on age, income and the benefits provided by an employer (Niles, 2015). This fractured system has also proved to be the most expensive in the world as evidenced by

data released from the OECD. During 2012—the most recent year on record for the US—healthcare spending accounted for 16.9% of the GDP. This percentage means that America spends 2.84 trillion dollars on healthcare every year with per capita spending reaching \$8745 in 2012 (OECD, 2014). Despite this enormous expenditure, there are serious questions about how effective the system actually is. The United States has a lower life expectancy than all but 7 of the 34 OECD countries and the fourth highest infant mortality rate after Mexico, Chile and Turkey. Even more telling, Americans tend to lose more years of potential life than other OECD countries which is another method of measuring the functioning of a nation's health system (OECD, 2014). Nevertheless, the health data of the United States does suggest that Americans are healthier than their counterparts in Guatemala, so it is reasonable to question whether or not Hispanics are receiving better care here in the United States than in their home countries.

Being a part of the US health system, Knox County health care suffers from many of the same problems as the nation as a whole such as cost and questions about the quality of care which in turn also affects the health of the Knox County Guatemalan community. In addition to these systemic effects that are affecting the US as a whole, the past ten years have seen Knox County's principal health institutions in a state of flux. The former Baptist Health Systems included a number of healthcare institutions in Knoxville and surrounding counties including the flagship campus Baptist Hospital Riverside situated on the Tennessee River, Baptist Hospital Cocke County, Baptist Hospital West and a number of smaller organizations such as senior centers and primary care clinics. Baptist Hospital West (currently Turkey Creek Medical Center) was the most recent and an extremely expensive addition to Baptist Health Systems. Baptist's investment in a

West Knoxville location led to a decline in morale at the flagship campus, and this decline in morale combined with poor operational and financial management ultimately led to an exodus in upper management leaving the board in charge and the hospital without clear direction (M. Cox, personal communication, April 14, 2015). Baptist Health Systems began searching for a buyer, but were unable to find a buy until another local hospital St. Mary's decided to purchase Baptist Health Systems forming Mercy Health Partners in 2008 (WBIR, 2013). Mercy was a short-lived health system in East Tennessee, and during its brief existence, also suffered from financial and morale issues as a result of both operational and financial mismanagement much like its precursor Baptist Health Systems (M. Cox, personal communication, April 14, 2015). In turn, Mercy Health Partners was acquired by Health Management Associates in 2011, and the seven hospital system converted into a for-profit system under the new name Tennova Healthcare ("Health Management Associates, Inc. Completes the Acquisition of Mercy Health Partners From Catholic Health Partners, Inc.," 2011).

More recently, Tennova has been discussing plans to construct a new hospital off Middlebrook Pike in the more affluent West Knoxville and close down Physicians Regional Medical Center (the former St. Mary's campus) located in North Knoxville (WBIR Staff and Kendall Morris, 2014). Despite Knoxville's recent urban renaissance, these plans coincide with a long period of suburbanization in Knoxville that began in the post-war period of WWII, and it will likely continue to marginalize the lower income and immigrant populations in Knoxville, including the Guatemalan population that is the subject of this text (Wheeler, 2005). If these plans are carried out as it seems they inevitably will, only three hospitals will remain in downtown Knoxville: East Tennessee

Children's Hospital (ETCH), Fort Sanders Regional Medical Center and the University of Tennessee Medical Center (UTMC). With a large portion of the Knoxville Guatemalan population living in the Lonsdale community, the closure of Physicians Regional will close their closest hospital and will put a greater financial burden on the two remaining adult facilities because poorer patients from North Knoxville will shift to these locations while the Middlebrook location will attract more affluent suburbanites.

While Physicians Regional may be closing its downtown location, one hospital in Knoxville is choosing to expand its presence there: East Tennessee Children's Hospital. ETCH is currently constructing a 245,000 square foot, \$75 million expansion of its existing facilities that includes a new neonatal intensive care unit in addition to facilities that cater to a number of chronic conditions such as cystic fibrosis (East Tennessee Children's Hospital). This project highlights the commitment that Knox County and the state as a whole have made to the community, and this commitment is beneficial to young, Guatemalan students here in Knoxville.

At the state level there are a number of programs that are designed to make healthcare affordable for minors, namely TennCare and CoverKids. So long as the children are US Citizens, which many are due to being born in the US, or a legal US resident then many of these children are eligible for TennCare or CoverKids so long as their families meet certain income requirements. TennCare is Tennessee's Medicaid program, and it covers children 0-1 whose families make up 195% of the federal poverty line (FPL), children 1-6 whose families make up 142% of the FPL and children 6-19 whose families make up to 133% of the FPL (Tennessee). For these patients TennCare offers coverage for a range of services covering the fields of physical, dental, mental and

visual health (Tennessee Government, 2015). CoverKids is a program of CoverTennessee which was developed during the last major reform of TennCare by the Bredesen administration, and it is very similar to TennCare except that its limit for coverage is 250% of the FPL. It has the additional requirement that CoverKids must be the enrollee's only healthcare plan ("CoverKids,").

These state initiatives are supplemented by other local initiatives that also directly effect the health of young, Guatemalan children. First, ETCH does not turn away any child regardless of their ability to pay. This policy is partially rooted in the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) because it requires that all hospitals accepting Medicare payments provide emergency medical treatment regardless of ability to pay, but they take this requirement a step further and apply it to non-emergency situations as well (Centers for Medicare and Medicaid Services, 2012). ETCH does not ask for payment upfront like many of the adult facilities do, and they offer a number of discounts for uninsured individuals, those who pay in full, and for those who are completely unable to pay, they have charity programs available (M. Cox, personal communication, April 14, 2015).

These programs provide a safety net for Guatemalan children who do not qualify for TennCare or CoverKids because of their immigration status and makes sure that they are receiving appropriate care. ETCH is also committed to providing quality, culturally competent care to their patients as well. They employ a staff of Spanish interpreters that serve the hospital who are either native speakers, hold relevant advanced degrees, have extensive experience abroad or a combination of the above. In the case of indigenous Guatemalans immigrants and their families, this service can be very useful, but very

often, these immigrants do not speak English or Spanish well because they speak one of Guatemala's native Mayan languages. This language barrier causes a number of problems because providers are often unaware of the linguistic diversity of Guatemala, but their access to Spanish interpreters is still beneficial because they are often able to identify that they are not Spanish speakers and find appropriate translation services through their telephonic translation line.

The Knox County Health Department (KCHD) also runs and manages a number of home-visit programs that are designed to promote health within the young population of the city, including Guatemalans. These programs include the Children's Special Services Program (CSS), Help Us Grow Successfully (HUGS), Newborn Screening Follow-Up, Newborn Hearing Screening Follow-Up, Childhood Lead Poisoning Prevention Program and Sudden Infant Death Syndrome (SIDS) Prevention. CSS is a program that is designed to help manage the health of children with significant physical disabilities, and may be useful to a small number of individuals within the Guatemalan community. Nevertheless, the latter five programs are likely to be the most beneficial to for this population. HUGS provides home-visits to pregnant women that last until the age of five, and according the KCHD, these visits are designed to "identify potential problems, provide education, and connect families with resources in their communities" (Knox County Health Department, 2015a) These other programs are similarly designed to identify risks and prevent health problems from arising in the future. KCHD also manages the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) that is designed to monitor and address nutrition problems in new mothers and children up to age five (Knox County Health Department, 2015b).

Other healthcare services available for Guatemalan youth come principally through the Knox County School System and the Community Schools Initiative in place in Knox County. The Community Schools operate on the premise articulated by Joy Dryfoos, one of the principal proponents of the Community Schools initiative, that “[c]hildren cannot learn unless their basic needs are met [and that] support services for children and families will have little impact unless cognitive development is taken care of” (2002). Basically, the idea is that the Community Schools must focus on providing for basic healthcare and social support needs in addition to providing quality education for these students. There are currently eight Community Schools in Knoxville, and these schools focus on providing for the basic needs of children as well as the community. They aim to improve family and community engagement by getting parents and community members in the school afterhours, provide tutoring and academic enhancement and provide for health and social support to students and the community (Great Schools Partnership). Lonsdale Elementary School, where a large community of Guatemalans live, boasts a nurse practitioner that can provide primary health services to children, mental health services provided through Helen Ross McNabb, visual health services through the Knox County School System and have recently began to implement a program designed to improve oral health and provide dental services to students in the school (A. Fritts, personal communication, December 9, 2014).

In order to determine the effect of these programs on these children’s health a number of surveys were distributed at three local Community Schools: Pond Gap, Norwood and Lonsdale Elementary Schools. Copies of this survey in both English and Spanish are attached in the appendix, but the main goal of these surveys was to gather

information around Guatemalans' and Hispanics' access to healthcare in order to make useful comparisons between the Guatemalan community and immigrants from other Latin American countries. They asked questions regarding medical insurance for parents and children, how recently they had seen certain healthcare providers, where they saw those practitioners and how they felt about the medical attention that they received from these institutions. A total of ten questionnaires were collected across these three locations and were analyzed to determine the participants' access to healthcare and the quality of care they were receiving. The participants included six Guatemalan families and four Mexican families.

The effect of these programs for young Guatemalan populations is documented through these surveys. Six Guatemalan families were surveyed and a number of indicators demonstrate their children are receiving significantly better medical attention than their parents. Five parents reported that their children had health insurance, and these same five parents also reported that their children had seen a physician within the past year. One reported that their child had never seen a physician. Access to these services are most likely assured through programs such as TennCare, CoverKids, etc. that were described above, but their responses regarding where their children received this healthcare highlighted an issue that should be addressed. Two families identified the KCHD as a location where their children have received healthcare, three families identified ETCH, and another family identified the community school itself as a location where the child received healthcare. The use of these locations highlights the fact that many of these children lack primary care providers (PCP) which in turn raises healthcare costs and limits coordination of care because their physician does not have a full and

accurate medical history (Sturm, Hirsh, Weselman, & Simon, 2014). These data are similar to the data collected for Mexican participants in this study who all reported that their children had seen a physician with the previous year, but also identified locations such as ETCH, UTMC, the health department and the Community School as locations for healthcare. One Mexican parent did identify Cherokee Health Systems for their child which is a primary care centered organization in Knoxville. One challenge for Guatemalan minors that may have been overlooked by this study taking place at elementary schools is that older children may have migrated with their parents and therefore be ineligible for TennCare or CoverKids because they are also not US citizens or permanent residents.

The majority of the children had also accessed dental and visual health services (5 and 3, respectively) over the course of the previous year, and once again these findings are likely largely a result of TennCare coverage for dental and visual health for minors. One question that should have been asked during the course of this study was whether or not the student received corrective lenses after an eye exam showing evidence of vision loss. A teacher at the school remarked that teaching the students to read is occasionally hindered by poor eyesight. This disparity between those receiving eye exams and those receiving treatment for those issues highlighted is not immediately explainable. The finances of the parents may play a role, but TennCare and CoverKids cover eyeglasses for children under the age of 21 (18 for CoverKids) so those financial barriers can be overridden. Another possible explanation could be related to cultural beliefs in the Guatemalan indigenous communities where eyes are often seen as capable of causing illness such as in the case of *mal de ojo* (Evil Eye) which is a common illness in

Guatemala (Harris, 1996). Due to the time constraints of this project, in-depth interviews to explore this possibility were not possible, but present a possible avenue for future investigation.

No parents in either the Guatemalan or Mexican populations reported their children ever receiving any type of mental health evaluation or treatment despite all participants having access to mental health services through Helen Ross McNabb. Due to the small sample size of this study, it is possible, albeit unlikely, that none of the parents' children have been in need of mental health services, but there are a number of other reasons that may explain why all the participants selected that their children had never received mental healthcare. Only one of the Guatemalan respondents reported not knowing where to go to receive medical treatment, but given that mental healthcare is largely nonexistent or out of reach in the majority of Guatemala, a possible explanation could be that the families do not have a real concept of mental healthcare and what it entails (Sullivan, 2001). A similar situation could occur in the Mexican population as evidenced in *Hunger for Memory: The Education of Richard Rodriguez* where Rodriguez describes a scene where he tries to explain the concept of a psychiatrist to his mother, but she cannot even conceive of sharing such intimate details with anyone except a member of the clergy—much less a clinician (Rodriguez, 1982). The traditional counselor-patient relationship that has become so common in western psychology and psychiatry seems completely foreign and merits the question of whether or not new methods of providing mental health services for these communities should be developed.

These data suggest that this community may need greater education about where and when to receive mental health care. Mental health services are available to students

through the Helen Ross McNabb Center in Knoxville, and although parents are not technically covered for these services, child therapy often employs family counseling which makes mental health affordable and relatively accessible for parents because family therapy will focus just as heavily on their behaviors and beliefs (A. Fritts, personal communication, December 9, 2014). The challenge with this arrangement is whether or not the Helen Ross McNabb Center has bilingual counselors or counselors who understand Hispanic and/or indigenous Maya culture sufficiently to provide culturally competent care. It has also been reported that Hispanics tend to have negative perceptions of mental health care believing that counseling will bring up too many bad feelings which may also explain why families are not utilizing these services (Jang, Chiriboga, Herrera, Martinez Tyson, & Schonfeld, 2011). The applicability of this study by Jang to the Guatemalan community can be debated because many of these individuals are culturally Mayan rather than Hispanic. Unfortunately, no study was available studying the beliefs of indigenous Guatemalan immigrants in the United States in regards to mental health care so this may represent an additional future avenue of research.

These data also neglect the mental health benefits that these students and their families receive unknowingly through the Community Schools program (R. Kronick, personal communication, April 2, 2015). In the afternoons the school aims to provide enrichment activities to help these students achieve academically, but at the same time, they work to build community between students, teachers, administrator, parents and siblings. For example, the school was involved in a program known as Light Up Lonsdale that was designed to get Christmas lights up in the community, increase traffic, decrease violence in the community through that extra traffic and also brighten up the area as a

whole (A. Fritts, personal communication, December 9, 2014). They also recently sponsored a reading workshop that was designed to provide parents the tools to help effect change in their students' reading abilities. This program certainly has educational promise, but it should also serve to help connect families to create a good family climate and strengthen social support which have been reported as protective factors against mental illness in children (Wille, Bettge, & Ravens-Sieberer, 2008).

The surveys administered also inquired as to the health status and access of the parents, and it evidenced a clear disparity between children's health and parental health in the Guatemalan community. While five of the six Guatemalan parents reported their children having seen a physician within the previous year, only one of the parents reported seeing a physician during this time period. Four others reported having never seen a physician, and one reported seeing a physician but not within the past year. Surprisingly, four of the six Guatemalan participants reported having seen a dentist within the previous year. This outcome may be a result of the generally poor state of dental health in Guatemala as a whole necessitating more dental interventions and the extremely painful and debilitating toll that dental health concerns can take on an individual. The survey also did not take into account the type of dental care received by the participants. It is very possible that dental care for them only included dental extractions rather than cleanings, restorative or preventative procedures.

Despite four reporting that they have never seen a physician, two reported that they had never avoided medical or dental care when they should have received treatment. These responses suggest that many individuals in the Guatemalan community may not be aware of appropriate times to seek medical care. Based on their responses to the

questions asking where they receive healthcare, it appears that they are not aware of where they can go to receive this care. Those that did seek medical care tended to receive care in local emergency rooms or through KCHD leading to higher costs and poor continuity of care in the adult population the same as with their children. In spite of the challenges associated with getting care in these environments, all of the Guatemalan participants and all but one of the Mexican participants in this study never reported receiving bad healthcare here in the US. The one individual who did report receiving bad care reported that there was no interpreter and that the provider paid very little attention throughout the treatment process. These responses brought into question the wording of the survey. Perhaps the survey should have asked whether or not translators were provided and how they felt about the treatment prescribed by the doctor in order to measure the quality of care they were receiving. Based on their experience with the Guatemalan healthcare system, it is very likely that the participants do not hold the same standards in regards to acceptable and poor medical care as are expected in the US.

These data also suggest that Guatemalan women may seek healthcare more often than Guatemalan men, principally for maternal healthcare. The only two Guatemalans involved in this study that reported seeking medical care were female, and one of these women marked Lisa Ross Birthing Center as the location where she has received health services. These women are also much more able to obtain health insurance to help them cover the costs of maternal healthcare because the TennCare and CoverKids programs also cover expecting mothers regardless of their immigration status ("CoverKids,"). KCHD also helps offer nutritional guidance and financial support for new mothers

through WIC, and they run a women's clinic that helps provide family planning and basic gynecological care (Knox County Health Department, 2015b, 2015c).

One area that should be researched more extensively is nutrition in this community. According to the United States Department of Agriculture (USDA) the Lonsdale community is low-income and lives at least one mile away from a supermarket which in urban areas are the commonly used criteria to identify a food desert (2015). The questionnaire administered briefly touched on nutrition by asking participants what a normal breakfast and a normal dinner looked like in their homes. Using the USDA MyPlate food circle as a guide, all of foods described by the Guatemalan families fell principally into categories such as proteins and grains (e.g. hamburgers, pizza, hot dogs, beans) while none mentioned other food groups such as fruits, vegetables and dairy. The Mexican families similarly described meals that were heavily biased towards proteins and grains, but there was at least a small amount of diversity. Many families described fruits and dairy products in addition to grains and proteins. Once again, vegetables were not mentioned.

The lack of healthy foods in their diet may be partially a result of lack of access due to living in a food desert, but there is also a cultural aspect that cannot be ignored. In Guatemala the diet focuses on foods high in carbohydrates so it is reasonable to expect that a similar diet would be followed after immigrating to the US, regardless of access to others vegetables (D. L. Lee, 2002). Supporting healthy eating and lifestyles is further complicated by Guatemalan views about what weight is healthy. Adam Fritts reported that Lonsdale Elementary School as a result of high obesity levels started an exercise program to encourage healthy levels of activity. As the girls began to lose weight, he said

that many parents began to withdraw their daughters because they were losing too much weight. Culturally, their ideal body image is somewhat overweight, despite the health problems that it can bring about (personal communication, December 9 2014). The question becomes how to educate these communities and effect change in a culturally competent manner.

One of the final observations of this study is that the Knox County Guatemalan population seems to be less healthy than their Mexican counterparts. They tend to see healthcare providers less often and also have unhealthier eating habits. Nevertheless, it appears that many of the barriers to access are related in the two groups. The two principal barriers among both groups turned out to be cost and lack of insurance except for the children who had access to government funded healthcare plans. Many also seemed to be unaware of when they needed to access care and where they would be able to receive this care at an affordable price. Few if any appear to have PCPs, and this lack of consistent primary care means that preventive and routine medicine is not being practiced as fully as it should within this community. Surprisingly, few participants cited language as a barrier to access, but once again, a majority of the Guatemalans reported never having seen a physician. The quality of care was also not assessed very accurately in this study.

This study has a number of limitations that may prevent it from being widely applicable. The most pressing issue in this study is the small sample size. Another important limitation is that this study was limited only to individuals who speak, read and write Spanish or English. There was no way of communicating with individuals who spoke native languages, and many of them do not attend the community school functions

due to significant language and cultural barriers. The lack of contact with these individuals means that the community least able to access care has also been neglected in over the course of this study. Their access to healthcare likely differs widely from that observed in these individuals. Another limitation is that while multiple schools were surveyed in order to look at Knox County as a whole, all of the Guatemalan participants came from one community so it may not be representative of the entire Knox County Guatemalan population. The final limitation is that information was only gathered via questionnaires. A number of interviews would have been beneficial for this study because more detailed information about cultural beliefs, hesitations and views towards the western system of medicine could be teased out more effectively through this medium. These questions must remain unanswered for future studies.

Policy Recommendations and Conclusion

In order to make meaningful changes in the overall health of the Knox County Guatemalan population changes have to be made on federal, state and local levels. Federally, immigration reform is the most pressing issue. According to the Migration Policy Institute, approximately 11.4 million unauthorized immigrants resided in the United States in 2012 making up approximately 3.6% of the entire US population (2012). As mentioned in the previous section, one of the greatest barriers to health care access is the lack of authorized immigration status so changes that reduce or eliminate the fear of deportation will help make the healthcare system less daunting and foreboding for not only the Knoxville Guatemalan community, but unauthorized immigrants throughout the country from both Hispanic and non-Hispanic backgrounds. The nation also has to make a commitment to training more PCPs so that there are enough providers to care for this

community and other communities nationwide, and it would be beneficial if a sizable number of those physicians were Hispanic because this would permit them to understand, integrate into and treat these underserved communities (Ruiz, 2005). At the state level, similar steps need to be taken in regards to training PCPs, and the state should revise the Certificate of Need (CON) granted to Tennova in order to prevent the closing of its flagship location in North Knoxville in order to open another location in the more affluent West Knoxville.

Many of the issues stated above are out of control of local politics. Knox County's local governments and citizens should play a role in lobbying for and supporting policies that will effect these changes, but there are a number of changes that can be made on the local level to improve the health of the Guatemalan community and other marginalized populations. Fortunately, the city of Knoxville and Knoxville Area Transit (KAT) do have a bus line (Line 12) that provides Guatemalans living in the Lonsdale community access to two grocery stores (Food City in Mechanicsville and the Kroger on Western Avenue), but the fact that these individuals must ride the bus limits how often they may go to the store. In turn, they may tend to choose cheaper, nonperishable items that do not provide as much nutritional value. Incentives should be developed to draw in new markets, and setting up a farmer's market in the community could also improve access to these important foods.

Unfortunately, access may be only part of the problem as even the Mexican participants at Lonsdale reported a more balanced diet than their Guatemalan counterparts. Cost and cultural beliefs are also important factors to consider. A detailed study of the cost of fruits and vegetables in these communities and the closest super

markets has not been undertaken but might be able to help elucidate why the Guatemalan community may not be choosing the healthiest food options. Cultural issues such as their traditional diets and their views on body image may also be important in explaining and developing educational programs for this community. The Community Schools and KCHD have been working to promote health equity through a number of different programs such as the exercise program at Lonsdale (A. Fritts, personal communication, December 9, 2014) and through a health educator that worked specifically with the Lonsdale Guatemalan community (J. Grubaugh, personal communication, December 10, 2014).

These individuals also need to receive regular and continuous care through a PCP. The challenges associated with this goal are numerous and are linguistic, educational and financial in nature. The linguistic barriers involved with accessing care were well documented by Sean Barton in his honors thesis and constitute a significant barrier to quality care in most institutions in Knoxville with the exception of ETCH (2014). Perhaps ETCH's model of having on staff interpreters is feasible for larger institutions and telephonic translation can suffice in other instances. It could also be useful to provide education on when and how to schedule an appointment with a physician in order to empower them with the ability to take charge of their own healthcare needs in the future.

The most substantial barrier that many of these individuals face is the ability to pay for the services rendered. A few of the participants were aware of Cherokee Health Systems, and this organization presents the best option for primary care services for the Knox County Guatemalan population. They are involved in both serving the inner-city and in Hispanic outreach which makes them a natural choice for the majority of this

community. They also implement a sliding fee scale for anyone that is uninsured (Cherokee Health Systems, 2011). More of the Guatemalan Community and the Hispanic Community as a whole should be made aware of the services provided by Cherokee Health Systems because receiving their primary healthcare through this organization represents a fiscally more prudent way of providing care, and additionally, it provides for greater continuity of care which will hopefully lead to more preventative care, earlier diagnoses and more effective treatment of any chronic conditions that might exist.

Another possible avenue to improve the health of this community in the future is to recall George Bush's Faith Based and Community Initiative (FBCI) that purported to develop public-private partnerships between the government and community organizations in order to address local challenges. The system put in place by the Bush administration had little effect because it did not help connect small organizations with more federal funding, but instead favored the larger organizations who were already receiving these funds (Kvasny & Lee, 2010). If local, state and federal governments could come up with a way to fund faith and community organizations providing health services then that would represent another option for many individuals in the Guatemalan and Hispanic communities as a whole, and if they began to use these clinics instead of emergency rooms then it would also help to lower overall healthcare costs.

Knoxville already has two religiously based health clinics that offer services to the working poor: The Free Medical Clinic and the Interfaith Clinic. These clinics would be perfect locations to provide primary care services for many of the uninsured Guatemalans and Hispanics, but there is one problem that likely prevents many in these communities from accessing care at these locations: documentation. The Free Medical

Clinic explicitly requires patients to be either US citizens or permanent residents while the Interfaith Clinic requires them to provide a 1040 tax form or two to three recent pay stubs and a social security card (InterFaith Health Clinic, 2012; The Free Medical Clinic). Two participants in the study, one Guatemalan from Lonsdale and one Mexican from the area surrounding Norwood Elementary School, reported seeking care at the Interfaith Clinic. The use of this clinic over the Free Medical Clinic may be a result of geographic proximity as the Interfaith Clinic is located in the historic Fourth and Gill neighborhood which is closer to both neighborhoods than the Free Medical Clinic on Chapman Highway. It may also signify that it is easier to maneuver around the Interfaith Clinic's documentation requirements because they do not explicitly require permanent residence or citizenship. Regardless, if these organizations were to change their rules regarding documentation and were to acquire greater funding then they could potentially fill the gaps of the recent Affordable Care Act, especially in regards to unauthorized immigrants.

Increasing health equity is a banner that should be taken up for both moral, financial and practical reasons. This text has explored some of the barriers to access and the problems that face the Guatemalan community in Knox County, Tennessee, and although it may only make up a small portion of the Knox County population, understanding and working to effect meaningful changes in the health of this community helps show the county's commitment to the idea that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" as the *Universal Declaration of Human Rights* states (United Nations, 1948). Many of the Guatemalan immigrants have grown up receiving inadequate health in their home country and traversed thousands of miles to end up in Knox County. They find themselves in one

of the most technologically advanced and richest countries in the world, but still lack reliable and consistent access to basic health services in their new home. Some of the policy recommendations in this text may help to alleviate those needs, but effecting those policy changes requires a change in the community to help support these movements both politically and monetarily.

Change will require the recognition that Guatemalans and other marginalized groups in Knox County are part of a complex ecology that connects everyone from the richest to the poorest in the community. Taking into account this ecology and recognizing the needs that are not being met for groups such as Knox County's Guatemalans is essential in continuing to strengthen Knoxville and Knox County as a whole. Revitalizing Knox County starts with investing in these communities that have the greatest need, and focusing on health equity is one way of investing in this community that can pay huge dividends in not only health but in areas such as productivity and education as well. The future of Knox County lies in how it support and develops these communities that will one day contribute more and more to its social, cultural and political life.

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Appendix

English Consent Form

Spanish Consent Form

English Questionnaire

Spanish Questionnaire

Informed Consent Form

Introduction:

You are invited to participate in a research study on Healthcare and Hispanics in Knox County because you are a Hispanic living in Knox County, Tennessee. The goal of this study is to determine how, where and if the Hispanic community can easily access healthcare in Knox County. Participation in this study is completely voluntary, and you may choose not to answer any questions with which you are not comfortable.

Information About Participants' Involvement in the Study:

I will be gathering data through two methods: questionnaires and interviews. The questionnaires will be distributed by myself or another individual associated with the community schools program such as the Community School Coordinator or an associated staff member (e.g. ESL teacher). The interviews will be conducted by me with a staff member of the Community Schools program present.

Risks:

There are no physical risks associated with this study, but discussing barriers to health access may be upsetting for participants to discuss. Questions about your health and medical condition will be asked through questionnaires and/or focus groups. Many people prefer to keep this information private, and every effort will be done to keep this information confidential. Please see the confidentiality statement below.

Benefits:

This project may help identify issues that affect medical care in Hispanic and other immigrant communities in Knox County. The results of this study will be shared with appropriate individuals in the community hopefully improve the healthcare that you, your family and other individuals receive.

Confidentiality:

The data collected over the course of this study will remain confidential and will be stored securely in a locked safe or on a password protected computer. It will be made available only to myself and other individuals involved with the study unless your express, written consent is given. No personal information will be used in oral or written reports that might link you to this study.

If you have agreed to participate in a focus group then I cannot guarantee that the information provided in these setting will remain confidential because there are a number

_____ Please initial here that you have read this page.

of people present. I will use no personal information in oral or written reports that may link you to this study, but I cannot guarantee that the other attendees will maintain your confidentiality. If there is information that you would like to share confidentially you may provide that information in writing or through a private conversation with me. In those cases the information will remain confidential.

Compensation:

There is no compensation for participation in this study. Food may be provided if you are participating in a focus group.

Contact Information:

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Taylor Cox, by email at tcx21@vols.utk.edu and/or by telephone at (865) 291-8605. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

Participation:

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

Consent:

I have read the above information and received a copy of this form. I agree to participate in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Formulario de consentimiento informado

Introducción:

Le invito participar en un estudio de investigación sobre la atención médica y los hispanos en *Knox County* (el condado de Knox) porque usted es hispano/a y un residente del condado de Knox County, Tennessee. El objetivo de este estudio es determinar cómo, dónde y si la comunidad hispana puede fácilmente obtener acceso a la atención médica en *Knox County*. La participación en este estudio es completamente voluntaria, y usted puede optar por no responder a cualquier pregunta con la que no se sienta cómodo.

Información sobre la participación en el estudio:

Voy a utilizar dos métodos para recoger información en este estudio: cuestionarios y entrevistas. Los cuestionarios serán distribuidos por mí mismo u otra persona asociada con el Community Schools Program tal como el coordinador del programa o un miembro del personal (p. ej. un maestro de ESL). Las entrevistas se llevarán a cabo por mí mismo junto a un miembro del personal del Community Schools Program.

Riesgos:

No hay riesgos físicos asociados con este estudio, pero es posible que las discusiones sobre el tema de las barreras a la atención médica puedan ser inquietantes. Se le hará preguntas acerca de su estado de salud y afección médica por medio de cuestionarios y/o grupos de enfoque. Muchas personas prefieren mantener su información médica privada, y se hará todo lo posible para mantener esta información confidencial. Por favor vea la declaración de confidencialidad abajo.

Beneficios:

Es posible que este estudio identifique problemas que afectan a la atención médica en las comunidades hispanas y en otras comunidades de inmigrantes en *Knox County*. Los resultados de este estudio serán compartidos con las personas adecuadas en la comunidad con el fin de mejorar la atención médica que reciben usted, su familia y otras personas.

Confidencialidad:

Los datos obtenidos en el transcurso de este estudio permanecerán confidenciales y guardados de forma segura en una caja fuerte cerrada o en una computadora protegida con contraseña. Los datos estarán disponibles sólo para mí y otras personas involucradas en el estudio (p. ej. mi consejero o un empleado de las escuelas de la comunidad) a menos que nos dé su consentimiento por escrito. No se usará información personal en informes orales o escritos que podría vincularlo con este estudio.¹

¹ _____ Favor de firmar de sus iniciales aquí para mostrar que usted ha leído esta página

Si usted ha consentido en participar en un grupo de enfoque (es decir una entrevista con muchas personas), no puedo garantizar que la información provista en este lugar se mantenga confidencial ya que habrá mucha gente presente. No usaré información personal en informes orales o escritos que podría vincularlo con este estudio, pero no puedo garantizar que los otros mantengan la confidencialidad de su información. Si hay información que le gustaría compartir confidencialmente, puede proporcionarla por escrito o por medio de una conversación privada conmigo. En esos casos, su información se mantendrá confidencial.

Remuneración:

No habrá remuneración por participar en este estudio.

Información de contacto:

Si usted tiene alguna pregunta en cualquier momento acerca del estudio o los procedimientos, (o si usted experimenta efectos adversos como resultado de este estudio), puede ponerse en contacto con el investigador, Taylor Cox, por correo electrónico a tcx21@vols.utk.edu y/o por teléfono al (865) 291-8605. Si tiene alguna pregunta acerca de sus derechos como participante, póngase en contacto con el responsable de cumplimiento de la oficina de investigación (Office of Research Compliance Officer) al (865) 974-3466.

Participación:

Su participación en este estudio es voluntaria; usted puede negarse a participar en cualquier momento sin ser sancionado. Si decide participar, puede retirarse del estudio en cualquier momento sin ser sancionado y sin perder los beneficios a los que tiene derecho en otras circunstancias. Si se retira del estudio antes de la finalización de la recopilación de datos, sus datos serán devueltos o destruidos.

Consentimiento:

He leído toda la información arriba, y he recibido una copia de este formulario. Consiento en ser un participante en este estudio.

Firma del participante: _____ Fecha _____

Firma del investigador: _____ Fecha _____

This questionnaire is part of a research project that I am undertaking for the Chancellor's Honors Program at the University of Tennessee, Knoxville. The goal of this project is to identify healthcare challenges facing minorities, specifically in Knoxville, and gauge your access to and your perceptions of the healthcare available in Knoxville. This questionnaire is completely voluntary, and is completely confidential. You may exclude any information that you do not feel comfortable releasing. Thank you for your help.

Date: _____

Sex: ☐ Male ☐ Female

Please mark your ethnicity:

☐ Hispanic ☐ White not Hispanic ☐ Black not Hispanic ☐ Asian of Pacific Islander ☐ American Indian
☐ Other: _____

What is your Nationality? (Please circle)

American Mexican Guatemalan Honduran Salvadoran Costa Rican
 Other (e.g. Chinese, Nigerian, etc.): _____

What language do you speak at home? (Please Circle)

English Spanish Mam K'iche' Q'eqchi' French Chinese Arabic
 Other (e.g. German, Russian, Swahili, etc.): _____

Do you have health insurance?

☐ Yes ☐ NoDo your kids have health insurance? (e.g. Private, TennCare, CoverKids) ☐ Yes ☐ No

When was the last time:

Past Year

Over a Year

Never

You went to a doctor:

☐☐☐

Your child went to a doctor:

☐☐☐

You went to a dentist/had teeth cleaned:

☐☐☐

Your child went to a dentist/had teeth cleaned:

☐☐☐

You received an eye exam:

☐☐☐

Your child received an eye exam:

☐☐☐

You saw a mental health professional (e.g. Psychologist):

☐☐☐

Your child saw a mental health professional:

☐☐☐

Have you ever avoided or not gone to the doctor or dentist when you felt you should? (Please circle)

Yes

No

If yes, why did you not go? (Please circle all that are applicable)

High Cost

Problems with language

Transportation

Lack of Insurance

Don't know where to go

Legal problems

Fear/Embarrassment

Could not miss work

Other

Doctor did not accept insurance

Could not get appointment

If other, why not? _____

Have you ever felt that you received bad care? (Please circle)

Yes

No

If yes, why did you feel that way?

No interpreter

Trouble filling prescription

Doctor seemed not to care

Did not understand doctor

Other

If other, why? _____

From which of the following organizations have you received healthcare? (Please circle)

Health Department

Interfaith Clinic

East Tennessee Children's Hospital

UT Medical Center

Other local hospital

Lisa Ross Birthing Center

Knoxville Area Project Access

Planned Parenthood

Free Medical Clinic

Doctor's office

Other

Community Schools

If other, where? _____

From which of the following organizations has your child received healthcare? (Please circle)

Health Department

Interfaith Clinic

East Tennessee Children's Hospital

UT Medical Center

Other local hospital

Lisa Ross Birthing Center

Knoxville Area Project Access

Planned Parenthood

Free Medical Clinic

Doctor's office

Other

Community Schools

If other, where? _____

What does a normal breakfast consist of in your house? Please include what you normally drink. If you don't normally eat breakfast, please put none.

What does a normal dinner consist of in your house? Please include what you normally drink.

What services would you like more information about? (e.g. medical, dental, eye exams, mental health, children's health, nutrition, etc.). Also, feel free to share any other needs you may have. (Please write on the back of the page.)

Este cuestionario es una parte de un proyecto de investigación que estoy emprendiendo para el programa de honores del canciller (Chancellor's Honors Program) de la Universidad de Tennessee, Knoxville. El objetivo de este proyecto es identificar los desafíos de la atención médica de las minorías, específicamente los Hispanos en Knox County (el condado de Knox), y medir su acceso y sus percepciones de la atención médica disponible. Este cuestionario es completamente voluntario, y es confidencial. Usted puede excluir cualquier información que usted prefiere no compartir. Gracias por su ayuda.

Fecha: _____

Sexo: ☐ Varón ☐ Mujer

Por favor seleccione su etnicidad:

☐ Hispano ☐ Blanco no hispano ☐ Negro no hispano ☐ Asiático o Isleño pacífico ☐ Indio Americano
☐ Otro: _____

¿Cuál es su nacionalidad? (Por favor ponga un círculo alrededor de su respuesta)

Americano Mexicano Guatemalteco Hondureño Salvadoreño Costarricense

Otro (p.ej. Chino, Nigeriano, etc.): _____

¿Cuál lengua habla usted en casa? (Por favor ponga un círculo alrededor de su respuesta)

Inglés Español Mam K'iche' (*Qatzijob'al*) Q'eqchi' (K'ekchi')

Francés Chino Árabe

Other (p.ej. Alemán, Ruso, Suajili, etc.): _____

¿Tiene usted seguro médico?

☐ Sí ☐ No

¿Tienen su hijos seguro médico? (p.ej. Privada, TennCare, CoverKids)

☐ Sí ☐ No

¿Cuándo fue la última vez que:

Año pasado Más que un año Nunca

Usted fue al médico?:

☐☐☐

Su hijo/a fue al médico?:

☐☐☐

Usted fue al dentista/limpieza de los dientes?:

☐☐☐

Su hijo/a fue al dentista/limpieza de los dientes?:

☐☐☐

Usted recibió un examen de los ojos?:

☐☐☐

Su hijo/a recibió un examen de los ojos?:

☐☐☐

Usted vio un profesional de la salud mental? (p.ej.

☐☐☐

Psicólogo):

Su hijo/a vio un profesional de la salud mental?:

☐☐☐

¿En algún momento ha usted evitado el médico/dentista o no ha ido cuando usted debería haber ido? (Por favor ponga un círculo alrededor de su respuesta)

Sí

No

Si sí, por qué no fue usted al médico? (Ponga un círculo alrededor de todos que aplican)

Coste alto

Problemas de lenguaje

Transportación

Falta de seguro médico

No sabía a donde ir

Problemas legales

Miedo/Vergüenza

No podía faltar al trabajo

Otro

El médico no aceptó el seguro

No podía obtener una cita

Si otro, ¿por qué? _____

En cualquier momento ha usted recibido mala atención médica?

Sí

No

Si sí, por qué sintió así?

No había intérprete

Problemas de comprar la receta

No le importó el médico

Problemas de comprar la
receta

Other

Mala explicación del
médico

Si otro, ¿por qué? _____

¿Cuales son las organizaciones que le han proporcionado atención médica a usted? (Por favor ponga un círculo alrededor de todas las organizaciones utilizadas)

Departamento de salud

Interfaith Clinic

East Tennessee Children's Hospital

UT Medical Center

Otro hospital local

Lisa Ross Birthing Center

Knoxville Area Project Access

Planned Parenthood

Free Medical Clinic

Oficina de un médico

Other

Escuela de la comunidad

Si otro, ¿donde? _____

¿Cuales son las organizaciones que les han proporcionado atención médica a su hijos? (Por favor ponga un círculo alrededor de todas las organizaciones utilizadas)

Health Department

Interfaith Clinic

East Tennessee Children's Hospital

UT Medical Center

Other local hospital

Lisa Ross Birthing Center

Knoxville Area Project Access

Planned Parenthood

Free Medical Clinic

Oficina de un médico

Other

Escuela de la comunidad

Si otro, donde? _____

Por favor describa un desayuno normal para su familia. Incluye las bebidas.

Por favor describa una cena normal para usted y su familia. Incluye las bebidas.

¿Acerca de cuales servicios quiere usted más información? (p.ej. medical, dental, exámenes de los ojos, salud pediátrica, nutrición, etc.) Además, por favor incluyan cualquier otra necesidad que tiene usted. (Utilice el lado opuesto si necesario)

References

- Allan R. Millet, P. M., and William B. Feis. (2012). *For the Common Defense: A Military History of the United States from 1607 to 2012* (2 ed.). New York: Free Press.
- At a glance: Guatemala*. (2013). Retrieved from:
http://www.unicef.org/infobycountry/guatemala_statistics.html
- Barton, S. (2014). *Health Care Delivery and the Hispanic Community in Knox County*. (University of Tennessee Honors Thesis Projects), The University of Tennessee, Knoxville, Knoxville. Retrieved from
http://trace.tennessee.edu/cgi/viewcontent.cgi?article=2789&context=utk_chanhonoproj
- Bowser, D. M., & Mahal, A. (2011). Guatemala: The economic burden of illness and health system implications. *Health Policy*, 100(2–3), 159-166. doi:
<http://dx.doi.org/10.1016/j.healthpol.2010.11.011>
- Centers for Disease Control. (2011). CDC in Guatemala. 2014, from
<http://www.cdc.gov/globalhealth/countries/guatemala/>
- Centers for Medicare and Medicaid Services. (2012). Emergency Medical Treatment & Labor Act (EMTALA). Retrieved March 29, 2015, from
<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/>
- Centro Hispano. Programs and Services. 2015, from
<http://www.centrohispanotn.org/programs/>

- Cherokee Health Systems. (2011). Community Outreach. from
<http://www.cherokeehealth.com/index.php?page=Services-Community-Outreach>
- Cohen, D. M. K. a. L. (2002). *The American Pageant* (J. L. Woy Ed. 12 ed.): Houghton Mifflin Company.
- . *Constitución Política de la República de Guatemala*. (1985). Retrieved from
https://www.oas.org/juridico/MLA/sp/gtm/sp_gtm-int-text-const.pdf.
- CoverKids. 2015, from <http://www.coverkids.com/WebForms/Eligible.aspx>
- Dryfoos, J. (2002). Full-Service Community Schools: Creating New Institutions. *Phi Delta Kappan*, 83(5), 393.
- East Tennessee Children's Hospital (Producer). Children's Hospital Expansion Project.
 Retrieved from http://www.etch.com/ways_to_give/expansion_project.aspx
- Furtado, J. M., Lansingh, V. C., Carter, M. J., Milanese, M. F., Peña, B. N., Ghersi, H. A., . . . Silva, J. C. (2012). Causes of Blindness and Visual Impairment in Latin America. *Survey of Ophthalmology*, 57(2), 149-177. doi:
<http://dx.doi.org/10.1016/j.survophthal.2011.07.002>
- Garza, J. A. (2009). The Long History of Mexican Immigration to the Rural Midwest. *Journal of the West*, 48(4), 88-95.
- Gómez-Sherlock, O. (2000). Healthcare Reform and Policies for the Poor in Mexico. In P. Lloyd-Sherlock (Ed.), *Healthcare Reform and Poverty in Latin America*. London: Institute of Latin American Studies.
- Gonzalez-Barrera, J. S. P. a. D. v. C. a. A. (2012). Net Migration from Mexico Falls to Zero—and Perhaps Less: Pew Research Center.

- Great Schools Partnership. Knox County's Community Schools Initiative. Retrieved March 29, 2015, from <http://www.greatschoolspartnership.com/programs/great-schools-programs/>
- Harris, J. (1996). "Someone Is Making You Sick": Conceptions of Disease in Santa Clara Ixtahuacán. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.
- Hawkins, W. R. A. a. J. P. (2007). Introduction: The Continuing Disjunction between Traditional and Western Medical Beliefs and Practices in Guatemala *Healthcare in Maya Guatemala*. Norman: The University of Oklahoma Press.
- Health Management Associates, Inc. Completes the Acquisition of Mercy Health Partners From Catholic Health Partners, Inc. (2011). [Press release]. Retrieved from <http://www.tennova.com/about/news-releases/health-management-associates-inc-completes>
- Hispanic Chamber of Commerce of East Tennessee. About the Chamber. Sobre Nosotros., from <http://www.hccet.org/about-the-chamber/>
- History of Knoxville. (2013). 2015, from <http://www.cityofknoxville.org/about/history.asp>
- HoLa. About Us. 2015, from <http://holafestival.org/about-us-2/>
- Hunter, B. (2007). Downtown Knoxville: Retail Development Strategy: H. Blount Hunter Retail & Real Estate Research Co.
- InterFaith Health Clinic. (2012). Home. Retrieved April 12, 2015, from <http://interfaithhealthclinic.org/>

- Jang, Y., Chiriboga, D., Herrera, J., Martinez Tyson, D., & Schonfeld, L. (2011). Attitudes Toward Mental Health Services in Hispanic Older Adults: The Role of Misconceptions and Personal Beliefs. *Community Mental Health Journal*, 47(2), 164-170. doi: 10.1007/s10597-009-9274-8
- Jones, M. D. (1995). The Solution is Prevention: The National Rural Health Care System in Nahualá. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.
- Knox County Health Department. (2015a). Home Visiting Department. from http://www.knoxcounty.org/health/home_visiting.php#screening
- Knox County Health Department. (2015b). Women-Infant-Children (WIC) Clinic. from <http://www.knoxcounty.org/health/wic.php>
- Knox County Health Department. (2015c). Women's Health. from <http://www.knoxcounty.org/health/womenshealth.php>
- Kvasny, L., & Lee, R. (2010). The paradoxical consequences of the White House faith-based and community initiative for black churches. *New Media & Society*, 12(4), 619-636. doi: 10.1177/1461444809342767
- Lebaron, A. (2012). When Latinos are not Latinos: The case of Guatemalan Maya in the United States, the Southeast and Georgia. *Latino Studies*, 10(1-2), 179-195. doi: <http://dx.doi.org/10.1057/lst.2012.8>
- Lee, D. L. (2002). "Tortillas Give Us Strength": An Assessment of Eating in Nueva Ixtahuacán. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.

- Lee, J. T. (2002). "If My Tooth Hurts I Pull It Out": Oral Health in Antigua Santa Catarina Ixtahuacán. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.
- Leyn, J. (1999). "The Sickness Was Too Strong": Medical Choice in Santa Catarina Ixtahuacán. In W. R. A. a. J. P. Hawkins (Ed.), *Healthcare in Maya Guatemala*. Norman: University of Oklahoma Press.
- Loewenberg, S. Guatemala's malnutrition crisis. *The Lancet*, 374(9685), 187-189. doi: [http://dx.doi.org/10.1016/S0140-6736\(09\)61314-3](http://dx.doi.org/10.1016/S0140-6736(09)61314-3)
- Lopez, D. v. C. a. E. P. a. M. H. (2014). Puerto Rican Population Declines on Island, Grows on U.S. Mainland. from <http://www.pewhispanic.org/2014/08/11/puerto-rican-population-declines-on-island-grows-on-u-s-mainland/>
- Maupin, J. N. (2008). Remaking the Guatemalan Midwife: Health Care Reform and Midwifery Training Programs in Highland Guatemala. *Medical Anthropology*, 27(4), 353-382. doi: 10.1080/01459740802427679
- Mejia, M. J. R. a. G. R. (2005). *Revolutionary Movements Atlas and Survey of Latin American History*. New York: Sharpe, Inc.
- Migration Policy Institute. (2012). Profile of the Unauthorized Population: United States.
- Niles, N. J. (2015). *Basics of the U.S. Health Care System*. Burlington: Jones & Bartlett Learning.
- Odem, W. B. a. M. (2011). Living Across Borders: Guatemala Maya Immigrants in the US South. *Southern Spaces*.
- OECD. (2014). OECD Health Statistics 2014 - Frequently Requested Data.
- OECD. (2015a). Infant mortality rates (indicator).

- OECD. (2015b). Life expectancy at birth (indicator).
- Patten, A. B. a. E. (2011). Hispanics of Guatemalan Origin in the United States. from <http://www.pewhispanic.org/2013/06/19/hispanics-of-guatemalan-origin-in-the-united-states-2011/>
- Reurings, M., Vossenaar, M., Doak, C. M., & Solomons, N. W. (2013). Stunting rates in infants and toddlers born in metropolitan Quetzaltenango, Guatemala. *Nutrition*, 29(4), 655-660. doi: <http://dx.doi.org/10.1016/j.nut.2012.12.012>
- Rode, S. S. (2000). If We Do Not Eat Milpa, We Die: The Cultural Basis of Health in Nahualá. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.
- Rodriguez, R. (1982). *Hunger of Memory: The Education of Richard Rodriguez*. New York: Bantam Dell.
- Ruiz, P. (2005). Hispanics' mental healthcare plight. *Behavioral Health Management*, 25(6), 17-19.
- Seiber, E. E., & Bertrand, J. T. (2002). Access as a factor in differential contraceptive use between Mayans and ladinos in Guatemala. *Health Policy and Planning*, 17(2), 167-177. doi: 10.1093/heapol/17.2.167
- Sturm, J. J., Hirsh, D., Weselman, B., & Simon, H. K. (2014). Reconnecting Patients With Their Primary Care Provider: An Intervention for Reducing Nonurgent Pediatric Emergency Department Visits. *Clinical Pediatrics*, 53(10), 988-994. doi: 10.1177/0009922814540987

Sullivan, E. R. (2001). Sadness in the Highlands: A Study of Depression in Nueva Santa Catarina Ixtahuacán. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.

Tennessee. Major Medicaid Eligibility Categories in Tennessee. 2015, from <http://www.tn.gov/tenncare/mem-categories.shtml#Children>

Tennessee Government. (2015). *TennCare Benefit Packages*. Retrieved from <http://www.tn.gov/tenncare/forms/benefitpackages.pdf>.

Tennessee Governor Signs Immigration Enforcement Law. (2011, 2011/06/15/). Article. *Mondaq Business Briefing*. Retrieved from http://go.galegroup.com.proxy.lib.utk.edu:90/ps/i.do?id=GALE%7CA259110246&v=2.1&u=tel_a_utl&it=r&p=ITOF&sw=w&asid=21249289221990093a04172e12a8fecc

The Free Medical Clinic. For Our Patients. Retrieved April 12, 2015, from <http://freemedicalclinic.net/for-patients/>

The World Bank. (2013a). *GDP (current US\$)*. Retrieved from: <http://databank.worldbank.org/data/views/reports/tableview.aspx>

The World Bank. (2013b). *Population, total*. Retrieved from: <http://databank.worldbank.org/data/views/reports/tableview.aspx>

United Nations. (1948). *Universal Declaration of Human Rights*. Retrieved from <http://www.un.org/en/documents/udhr/index.shtml#a25>.

United Nations. (2014). *Human Development Indicators*. Retrieved from: <http://hdr.undp.org/en/countries/profiles/GTM>

United States Census Bureau. (2010a). *American FactFinder: Knox County, TN*.

Retrieved from

<http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>.

United States Census Bureau. (2010b). *American FactFinder: Tennessee*. Retrieved from

<http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>.

United States Census Bureau. (2010c). *American FactFinder: United States*.

United States Department of Agriculture: Economic Research Service (Producer). (2015).

Food Access Research Atlas. [Interactive Map] Retrieved from

<http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx>

WBIR (Producer). (2013, 28 March 2015). Georgia development firm to buy old Baptist Hospital building. Retrieved from <http://downtown.wbir.com/news/news/46652-georgia-development-firm-buy-old-baptist-hospital-building>

WBIR Staff and Kendall Morris. (2014, 26 March 2015). Plans for new West Knoxville hospital move forward. *WBIR*. Retrieved from <http://www.wbir.com/story/news/health/2014/11/19/certificate-of-need-approved-for-new-west-knoxville-hospital/19277983/>

Wheeler, W. B. (2005). *Knoxville, Tennessee: A Mountain City in the New South* (2 ed.).

Knoxville: The University of Tennessee Press.

- Wille, N., Bettge, S., & Ravens-Sieberer, U. (2008). Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *European Child & Adolescent Psychiatry, 17*, 133-147.
- Wilson, K. E. (1996). "Your Destiny is to Care for Pregnant Women": Midwives and Childbirth in Nahualá. In W. R. A. a. J. P. Hawkins (Ed.), *Health Care in Maya Guatemala*. Norman: University of Oklahoma Press.
- World Bank. (2015). GINI Index (World Bank estimate). Retrieved 14 February 2015, from <http://data.worldbank.org/indicator/SI.POV.GINI>